B. CENTER FOR MENTAL HEALTH SERVICES

Overview

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA	$451,268,000	$513,737,000	$588,737,000	$75,000,000

Each year, as many as 44 million American adults experience some form of mental disorder. Of these adults, an estimated 10 million experience a serious mental illness of such intensity and duration that employment, physical health, housing, and the overall quality of life for them and their families are dramatically affected. Estimates for the Nation=s children are equally significant. Approximately 13.7 million children and adolescents between the ages of 9-17 experiencing a diagnosable mental disorder in any one year. Of these children, 3.5 to 4 million have a serious emotional disturbance of such severity that it affects the child=s ability to function at home, to learn at school, and to engage in neighborhood or community activities.[1]

Despite the millions of American adults, adolescents, and children who experience mental disorders and serious emotional disturbances, fewer than one in four receives appropriate treatment for his or her disorder. Of those who do not receive care, many appear in other service systems that are not able to respond fully to their needs, among them welfare, education, or justice.

From Institutions to Community Systems of Care

CMHS programs are the legacy of decades of work to create community-based systems of care to people with serious mental and emotional disorders to live productive and fulfilling lives within their communities. The availability of empirically-validated models of community interventions has been linked to the important and historic trend of reduced institutional care and increased community mental health services. In 1981, almost two thirds of dollars spent by State mental health agencies went to inpatient hospitals. In 1993, dollars spent nationwide for community-based services exceeded those spent for inpatient services for the first time. State and county mental hospital bed utilization has decreased from 413,066 beds in 1970, to 93,058 beds in 1992. It is expected that the decline in expensive institutional bed utilization will continue as increasingly effective community-based services become available. However, major challenges remain in creating community systems of care that respond to the needs of persons with mental health problems through integrated services that enhance self-sufficiency and maintain normal connections to home, school and work, while preserving the respect and dignity owed to all citizens.

[1] It is estimated that a significant number of children below the age of 9 suffer from serious emotional disturbance; unfortunately, insufficient research has been conducted to determine with precision the prevalence rates in these very young children.

People with the most serious mental disorders--psychoses such as schizophrenia and affective disorders such as bipolar illness and severe depression--frequently exhaust their health insurance benefits, leading to reliance on the public mental health care system and frequently to Medicaid and Medicare. In addition, individuals with serious mental illnesses often require services and support not only from the mental health sector, but also from a variety of public and private agencies to help with housing, primary health care, rehabilitation, employment, substance abuse, and other supportive service needs. Yet, all too often, the system of services they must negotiate is fragmented, confusing, and rapidly changing. Indeed, consumers and providers of mental health services face a host of additional uncertainties in the wake of State-level health care reform initiatives, the growth of managed care, national welfare reform, and Social Security disability reform. What has been called for has been a central resource to help address these nationwide issues.

The Role of the Center for Mental Health Services

In its unique dual role, CMHS supports both knowledge development about and the delivery of comprehensive mental health services, both designed to bridge the gap between access to care and the mental health needs of Americans. Through its national programs, CMHS develops new strategies and highlights effective practices, both of which are grounded in the latest research-based treatments and support services. By promoting integrated community-based services, CMHS has opened the door to a comprehensive service system--often termed a system of care--for those in need of continuing mental health intervention. Through its formula and discretionary programs, including the Block Grants for Community Mental Health Services, Projects for Assistance in Transition for Homelessness (PATH), Knowledge Development and Application, and Comprehensive Mental Health Services for Children and their Families, CMHS provides integrated services to the most vulnerable populations, from children and adolescents with serious emotional disturbance to adults with serious mental illness, from those with mental illness involved in the criminal justice system to those homeless on our nation=s streets.

Initiatives supported in FY 1999 and 2000 will continue to focus on the SAMHSA GPRA program goals using the five organizing principles that underlie CMHS=s mission:

Improving Today=s Mental Health System for Tomorrow- Through its Knowledge Development and Application (KDA) program that focuses on the delineation of exemplary practices to meet difficult mental health service needs, CMHS works with States and communities to develop, implement, and evaluate state-of-the-art service approaches to meet the most challenging mental health service issues for children, adolescents, and adults. CMHS has continued its work to ensure application of exemplary practices at the local level through both its Community Action Grant program and support for special projects that synthesize our latest understanding of mental illness treatment approaches and their application in the field. In addition, the Comprehensive Mental Health Services for Children and Their Families program continues to foster the development of innovative community-based, family-centered systems of care to address the comprehensive needs of children with serious emotional disturbances and their families.

Linking Mental Health with Other Service Systems - CMHS has forged numerous strategic partnerships with other national, state, and local organizations to respond to issues that transcend the role of mental

health services alone. For example, in collaboration with SAMHSA=s Center for Substance Abuse Treatment and the Department of Justice=s National Institute of Corrections, CMHS supports the national GAINS Center, a program that trains teams of mental health, substance abuse, and corrections personnel to deliver integrated services within the criminal justice system to individuals with co-occurring mental health and substance use disorders. In two important areas that focus on building resilience and promoting mental health in extraordinary circumstances, CMHS staff work closely with the Federal Emergency Management Agency (FEMA) to provide crisis counseling services to people who have experienced the trauma of natural and terrorist disasters. Similarly, CMHS staff work in partnership with the DHHS Office of Refugee Resettlement to address the mental health needs of refugees. These important interagency partnerships are just a few of the many linkages that bring mental health service focus to key human services programs. Other agreements have been developed in such areas as work with the homeless population, individuals with or at risk of HIV/AIDS, children=s mental health, employment interventions, managed care, and mental health professional workforce training.

Engaging Consumers as Partners in Change - CMHS serves increasingly as the Federal voice for the rights of mental health consumers across the nation, a role that has become increasingly important in the wake of the health care revolution sweeping the country. CMHS continues to work to protect the rights of consumers in institutions through the Protection and Advocacy for Individuals with Mental Illness program, and serves in a federal leadership role not only in promoting consumer and family participation in the planning and delivery of services, but also in educating the public, policy makers, and the media about the damaging effects of the continuing stigma associated with mental illness.

Addressing Emerging Mental Health Needs - Just as the health care system is changing, the mental health needs of our nation, too, are in continual flux. Thus, throughout its work, CMHS has infused an awareness of the disparate ways in which mental health services must be provided, based on cultural and ethnic issues, gender, age, disability, and geography. CMHS staff continuously assess and evaluate the mental health service system and work with health care providers and consumers to identify emerging mental health issues arising from the increasingly diverse community we serve. The aim is to work actively to develop initiatives to meet these emerging needs.

Implementation of Agency Program Goals

CMHS programs support three of the four SAMHSA/GPRA goals. CMHS=s Knowledge Development and Application Programs support both, Goal 1: Bridging the gap between knowledge and practice, and Goal 2: Promoting the adoption of best practices. Goal 1: Bridging the gap between knowledge and practice will be measured in the GPRA Performance Plan by the success of the following KDA programs: the Access to Community Care and Effective Services (ACCESS), and the Employment Intervention Demonstration Project (EIDP). Goal 2: Promoting the adoption of best practices will be measured by the success of the Knowledge Exchange Network (KEN), and the Community Action Grant (CAG). Finally, CMHS=s programs including Block Grants for Community Mental Health Services, Projects for Assistance in Transition for Homelessness (PATH), and Comprehensive Mental Health Services for Children and their Families, support SAMHSA/GPRA Goal 3: Assuring Services Availability/Meeting Targeted Needs. See the budget narrative under each respective program for further description. See also the GPRA

Performance Plan for specific performance measurement information.

FY 2000 Agenda

For Fiscal Year 2000, CMHS has designed a portfolio that builds on the strengths of current program knowledge and addresses emerging needs in communities throughout the country. The CMHS portfolio is described in detail in the sections that follow. Moving into the 21st century, CMHS will facilitate access to a mental health care service system that is proactive, responsive, accountable, and integrated whether needed by a child, adolescent, adult or elder. The product will be an America in which even those who are most vulnerable and most in need are full and active participants in the fabric of their communities. The vision of a mentally healthy America is the guiding principle that drives the FY 2000 agenda of the Center for Mental Health Services.

CMHS proposes significant increases in Federal support for community mental health services through the Mental Health Block Grant (+24%) and the PATH program (+19%). These programs help States ensure that state-of-the-art treatments and innovative community-based programs are available to public sector mental health clients. The proposed increases in Federal support will enable the States to serve a larger proportion of the nation=s most vulnerable populations, including homeless people, children, minorities, and women.

Though no increase is requested in FY 2000 for the continuing KDA funded programs, CMHS will initiate several new projects to help States and communities address some the most challenging issues facing the field. New projects will focus on the mental health repercussions of bioterrorism, employment concerns for persons with disabilities, and a continuum of care for individuals living with HIV/AIDS. Additionally, CMHS will expand the Community Action Grant program and develop peer to peer technical assistance networks.

CMHS is also continuing a major KDA program initiated in FY 1999 that supports the delivery and improvement of mental health services in our nation=s schools. This ambitious program is designed as a comprehensive, interagency collaborative approach linking local and State mental health service providers with schools. School districts will implement a wide range of early childhood development, early intervention and prevention, and mental health treatment services that appear to have the greatest likelihood of preventing violence among children.

Because the requested budget increases are for ongoing CMHS programs, performance information is located primarily in the GPRA Performance Plan.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
Center for Mental Health Services
Mechanism Table
(dollars in thousands)

	FY 1998 Actual		FY 1999 Enacted		FY 2000 Request	
Knowledge Development and Application:	**No.**	**Amt.**	**No.**	**Amt.**	**No.**	**Amt.**
Grants:						
Continuations	17	$1,998	76	$8,064	161	$40,848
Competing:						
New	100	10,657	114	36,410	86	6,440
Renewal	---	---	---	---	---	---
Supplements:						
Administrative	---	352	---	---	---	---
Subtotal, Grants	117	13,007	190	44,474	247	47,288
Cooperative Agreements:						
Continuations	48	15,280	79	27,984	68	22,539
Competing:	---	---	---	---	---	---
New	45	15,511	9	2,800	4	1,647
Supplements:						
Administrative	(34)	1,740	---	1,050	---	---
Subtotal, Coop. Agreements	93	32,531	88	31,834	72	24,186
Contracts	30	12,426	36	21,656	44	26,490
Total, Knowledge Develop & Appl	**240**	**57,964**	**314**	**97,964**	**363**	**97,964**
Children's Mental Health Services:						
Grants:						
Continuations	27	41,660	25	33,514	51	63,695
Competing:						
New	14	12,571	28	28,000	---	---
Supplements:						
Administrative	---	3,142	---	---	---	---
Subtotal, Grants	41	57,373	53	61,514	51	63,695
Cooperative Agreements:						
Continuations	---	---	---	---	1	1,000
Competing:						
New	---	---	1	1,000	---	---
Supplements:						
Administrative	(1)	595	---	---	---	---
Subtotal, Coop. Agreements	---	595	1	1,000	1	1,000
Contracts	15	14,959	18	15,486	18	13,305
Total, Children's Mental Health Services	**56**	**72,927**	**72**	**78,000**	**70**	**78,000**
Protection & Advocacy:						
Total, Protection and Advocacy	**56**	**21,957**	**56**	**22,957**	**56**	**22,957**
Set-Aside (Non-Add)	---	(439)	---	(459)	---	(459)
PATH:						
Total, PATH	**56**	**23,000**	**56**	**26,000**	**56**	**31,000**
Set-Aside (Non-Add)	---	(690)	---	(779)	---	(929)
Mental Health Block Grant:						
Block Grant	**59**	**275,420**	**59**	**288,816**	**59**	**358,816**
Set-Aside (Non-Add)	---	(13,771)	---	(14,441)	---	(17,941)

B. CENTER FOR MENTAL HEALTH SERVICES
1. Knowledge Development and Application (KDA) Program

Authorizing Legislation - Section 501 of the Public Health Service Act.

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA	$57,964,000	$97,964,000	$97,964,000	---

2000 Authorization

PHSA Section 501 ..... Indefinite

Purpose and Method of Operation

The CMHS Knowledge Development and Application (KDA) program makes a difference to people by promoting the continuous improvement of service delivery systems for children and adults with serious mental health problems. KDA projects improve service systems by providing effective cross-system service models and by reducing service delivery system fragmentation. The KDA program includes multi-site studies and other knowledge development activities that identify the most effective service delivery practices, knowledge synthesis activities that translate program findings into useful products for the field, and knowledge application projects that support adoption of exemplary service approaches throughout the country. Results from the KDA programs are widely disseminated throughout CMHS=s programs including the Comprehensive Mental Health Services for Children with Serious Emotional Disturbance and their Families Program, the Projects for Assistance in Transition from Homelessness (PATH) program, and the Mental Health Block Grant program. This dissemination creates a comprehensive approach that supports adoption of evidenced-based treatment practices in mental health. In FY 1999, the Violence in Schools Initiative: Expanding Resiliency was added to this comprehensive approach to support improved services and outcomes for the millions of persons suffering from serious mental problems.

Violence in Schools Initiative: Expanding Resilience

On October 21, 1998 the President signed the Omnibus Appropriation Act (P.L. 105-277) which provides a minimum of $100 million for the Violence in Schools Initiative to be carried out in collaboration with the Department of Education and the Department of Justice. The CMHS project within this initiative will be known as AExpanding Resiliency@. This project will support delivery and improvement of mental health services in schools for children who are at risk of violent behavior. The Act provides CMHS with $40 million which represents 41% of the KDA budget in FY 1999 and FY 2000.

CMHS=s ambitious program is designed to make the most effective use of these resources, using proven interventions and a comprehensive and collaborative interagency approach linked to local and State mental health entities. School districts will implement a wide range of early childhood development, early

intervention and prevention, suicide prevention, and mental health treatment services that appear to have the greatest likelihood of preventing violence among children.

The program=s goal is to increase the percentage of knowledge application activities that change user practices or are adopted by others. Through this initiative CMHS hopes to decrease the rate of violence in schools and increase the percentage of proposed mental health activities actually implemented in schools. CMHS will collect data on the number or percentage of students engaged in violent behavior, incidents of serious and violent crime in schools, suicide attempts, and students suspended and/or expelled from school.

This Initiative includes the following five components:

The Safe Schools, Healthy Students Program is an interagency grant program linking CMHS, the Department of Education and the Department of Justice, which will help school districts develop and implement a community-based comprehensive strategic plan which must be linked to the local and/or State mental health entity. This program will target interventions that have been empirically tested and demonstrated successfully in the fields of child development and education. The initiative provides funding for six different elements of activities including: mental health treatment services, early childhood development services, prevention and early intervention, school security, safe school policies, and educational reform,. SAMHSA has responsibility for both mental health treatment services and early childhood development services, as follows.

- Mental Health Treatment Services: Each school district must describe in detail a plan for identifying and serving children with mental health needs. Interventions link directly to the troubled and vulnerable children who are at risk for emotional/behavioral problems. There will be at least three categories of activity: 1) screening and assessment in school settings, 2) provision of effective school-based mental health services, and 3) provision for referral and follow-up of children with more severe problems and their families by the local public mental health services organization. Examples of such activities would incorporate a wraparound approach to service delivery inclusive of individual and family counseling, multi-systemic theory, and functional family therapy.

- Early Childhood Development Services: Each school district must describe how their plan to support early childhood development services will promote safe and healthy environments for children to live and learn. While serious violence is typically not exhibited until later in life, schools are increasingly recognized as a key component in the healthy growth and development of individual children, creating a potent environment early in life. The quality of child care, early education, and family support programs are viewed as affecting the probability of late aggression and violence. Early childhood development services include effective parenting programs and home visitation to teach parents and other caregivers, make quality early assessments and provide ongoing monitoring of progress, focusing on the strengths of families.

School Action and Piloting Grants - Modeled after our highly successful Community Action Grants, this component includes research coordination with NIMH. This program offers many community groups, including families, providers, social agencies, non-profit organizations and faith communities the opportunity

to Amanualize@ their existing violence prevention programs targeting children with emotional and behavioral difficulties and prepare programs for evaluation by a panel of experts for further refinement and dissemination. Schools and communities are given the opportunity to highlight current innovative programs and subject them to the usefulness of evaluation and consultation on dissemination strategies.

Technical Assistance Center - CMHS will link with local communities and schools to net to engage them in support of mental health interventions on behalf of all children with their public mental health programs.

Public Education/Awareness Campaign - A public awareness campaign will target organizations, rather than individuals as is typical in most similar events, that have or should have an interest in the well being of children such as foundations, PTAs, schools, and universities.

Innovations- This effort will provide an opportunity, using interactive technological advances, for the development of creative alternatives to reduce violence and develop training options to address aggressive behaviors to be used by students and their families, as well as educators and other concerned community leaders. Much of these technologies have baseline research supportive of their utility and seem very promising, especially for the sometimes difficult to engage adolescent student.

Knowledge Development Accomplishments:

Homeless Persons with Mental Illness: The Access to Community Care and Effective Services and Supports (ACCESS) Program, initiated in FY 1993, was designed to evaluate the effectiveness of integrated service approaches for this vulnerable population. It is the last year of program implementation and data collection. Among the most important observations are:

- *Homeless persons can be engaged.* The last year of data collection continues to demonstrate that it is possible to engage some of the hardest-to-reach homeless people, that is, persons with severe mental illnesses, into services after a relatively brief period of time--52 days on average even for those most difficult to approach.

- *Improvements in client outcomes from comprehensive services are dramatic.* The newest wave of data collection continues to show significant improvement in service outcomes. Within the first 3 months after being engaged in services, these individuals reported a 45% reduction in the number of days homeless; and after 12 months, the number of days homeless had reduced by 74%.

- *Integration efforts yield improved service linkages.* Findings, published in the *American Journal of Public Health* in October 1998, show that more integrated service delivery system result in better housing outcomes for homeless persons. There are still policy and environmental variables that affect systems integration that require further evaluation. For instance, even when sites employ similar strategies and are equally successful in putting them in place, they may still differ in the level of integration achieved.

The ACCESS program contributes to the achievement of Goal 1-- Bridging the Gap between Knowledge

and Practice. See GPRA plan for standard measures and program specific measures, and update data.

Employment of Persons with Serious Mental Illness: The Employment Intervention Demonstration Program (EIDP), initiated in FY 1995, was designed to identify model interventions that achieve the best employment results for people with severe mental illness. While far from complete, the study is already yielding important information. Among the most important preliminary observations are:

- *People with Serious Mental Illness are Employable*. Over half (52%) of those receiving services for 9 months or more had at least one employment experience, working an average of 20 hours per week an earning an average of $5.85 an hour. Those who worked held more than one job, with an average of 1.9 jobs per person employed.

- *People with Serious Mental Illness are Productive.* The work motivation among more than 1,600 clients in the study is very high and has remained very high during the course of the study. The productivity potential of EIDP participants is evident in the fact that they held a total of 1449 jobs earning $1.8 million dollars in the first eight quarters of the EIDP. They logged 346,405 hours on-the-job and 18% worked full-time.

- *Integrated Team Approach Locates Jobs*. Preliminary results from some sites show the advantages of providing integrated team services to locate jobs for persons with severe mental illness over traditional, non-integrated approaches.

The EIDP contributes to the achievement of Goal 1-- Bridging the Gap between Knowledge and Practice. See GPRA plan for standard measures and program specific measures.

Homeless Prevention : The CMHS/CSAT Collaborative Program to Prevent Homelessness is in its final of three years of program activity. Preliminary observations demonstrate that there are effective ways to engage clients with serious mental illnesses and/or substance use disorders in prevention services and treatment. Heretofore, many authorities discounted the advantages of preventive services for persons at risk for homelessness. The experimental programs appear to have very positive retention rates, which anticipate stronger prevention outcomes. Also, the program has been able to design a multi-site study that successfully incorporates eight diverse communities, service populations, and intervention strategies, and thus will generate results more reflective of the larger national community and which will allow easier replication in more diverse communities throughout the Nation.

Effects of Managed Care on Adults with Serious Mental Illness: CMHS has collaborated with its SAMHSA partners to fund a set of multi-site studies looking at the impact of managed care on several vulnerable populations -- SMI adults, mothers and their children, and substance abusers. The goal of this program is to develop descriptive information on substance abuse and mental health services available to clients in the managed care environment and to evaluate the impact of managed care systems on the use, cost and outcomes of services for these populations.

In its final year of funding, this ground-breaking program has developed considerable technology for looking

at consumers of mental health and substance abuse services within a managed care environment. These advances include:

- New protocols for interviewing consumers with SMI regarding service quality and outcomes.
- A taxonomy for classifying types of managed care programs.
- Population-based sampling methodology for recruiting persons with SMI who are not engaged in the service system.

Furthermore, this project includes both the prospective study of 1300 managed care (MC) and fee-for-service (FFS) Medicaid enrollees, as well as an administrative Medicaid database study, which will be the largest of its kind to look at administrative data for this target population. CMHS expects that this program will greatly expand the knowledge base on service quality and outcomes in managed care settings. Data from this study will have tremendous policy implications for the fields of mental health services and managed care. Preliminary findings include:

- MC programs appear to enroll higher functioning consumers, as indicated by marital and parenting status. Two-thirds of enrollees in managed care indicated that they are living with children, whereas only half of those in FFS indicated the same.
- Consumers in MC programs were less likely to receive long-term inpatient care (1.4% vs 5.3% FFS).
- Consumers in FFS programs were five times more likely to be receiving newer medications, such as clozapine.
- Consumers in MC programs were more likely to get primary health care (61% vs 50% FFS).
- FFS programs cost consumers more of their own money. One-fourth of consumers in FFS had out of pocket costs for health and behavioral health services, whereas fewer than one-sixth of managed care enrollees had out of pocket costs. Similarly, more FFS enrollees reported receiving mental health services which were not covered by their insurers.

Effects of Managed Care on Children with Serious Mental Illness: Preliminary findings from the Managed Care Impacts on Children Study conducted at the University of Pittsburgh show the following trends:

- Managed Care Organization (MCO) participants are 1/3 as likely to use specialty MH services as compared with Fee-for-Service (FFS).
- African-American youth in MCO are half as likely to use MH specialty care as are European-American youth in FFS.

- Children with psychiatric hospitalizations are less likely to join an MCO and tend to disenroll at a higher rate.

- MCO participants are more likely to experience delays in care.

- Families liked joining the MCO for the non-mental health benefits: eye, no co-pay pharmacy and dental benefits.

- Parents would join the MCO for non-mental health benefits, yet enroll their kids in FFS to get the more flexible MH benefits for their children.

HIV/AIDS Demonstration: This program was a collaborative effort of SAMHSA, CMHS, HRSA, and NIH. It was the first Federal effort to develop models of delivery of mental health services to people living with and/or affected by HIV/AIDS. This program has shed new light on how to develop services and develop systems of care. Findings from the program indicated that early intervention with mental health services can improve adherence to medical and other treatments. Mental health treatment services and HIV education play an important role in preventing children and adolescents whose parents have HIV or AIDS from acquiring the virus themselves. These and other important findings are currently being disseminated to the field.

Other Ongoing Knowledge Development and Application Activities

During the past three years, CMHS has developed a strong, responsive knowledge development study portfolio that addresses the areas of greatest opportunity for service improvements. CMHS recognizes that this knowledge needs to be combined with learning from other sources--including the National Institute of Mental Health--to maximize its utility. These programs will supply more lessons, more best practices and more opportunities for CMHS to work with the field to achieve improved services and better outcomes for children and adults.

- *Consumer and Family Network Grants* provide consumers and their families with support and assistance in contributing to the development of effective treatment programs for persons with mental illness.

- *Consumer and Family Technical Assistance Centers* provide technical assistance to consumers, families and supporters of persons with mental illness with two important supports: (1) explicit training and assistance designed to enhance the skills persons need to be effective participants in policy development, decision-making and strategic planning, including development of leadership skills; and (2) technical support for the creation and maintenance of a communication network among consumers, families and supporters which facilitates the flow of information and provides opportunities for sharing lessons learned and good advice among peers.

- The *Effectiveness of Consumer-Operated Human Services* program examines consumer-operated, self-help programs providing human services to explore the extent to which

these service programs are effective. This multi-site study is: 1) determining what effect participation in consumer-run services has on selected client outcomes; 2) examining program costs; 3) examining whether these programs promote greater levels of personal responsibility and independence; and 4) examining the differences in the training, organization, infrastructure and resource needs of consumer-operated self-help programs from similar community-based, professionally-operated services.

- The *Circles of Care: Designing and Assessing Service System Models for Native American Indian and Alaska Native Children and Their Families* project is providing a unique opportunity to enfranchise Native American communities in the national drive toward establishing effective systems of care for children with serious emotional disturbances. It also has established Alaboratories@ to enable culturally distinctive communities to establish their own outcome expectations for the treatment of their children, a cornerstone of the commitment of both CMHS and the Administration to culturally competent, relevant mental health and substance abuse treatment programs in the United States.

- The *SAMHSA-wide Starting Early/Starting Smart* program was initiated in FY 1997 to identify interventions that have the best chance of preventing serious emotional disturbances and substance abuse in children ages birth to seven. The study is designed to develop and test a comprehensive approach for working with families with young children who are at risk for mental health and substance abuse problems due to family history and environment.

- The study on *Mental Health Services for Aging Persons in Primary Care Settings* is developing and measuring the effectiveness of models for improving the connection between mental health and primary health care. This initiative includes the active collaboration of the Health Resource Services Administration=s Bureau of Primary Health Care and the Department of Veterans Affairs. The need to better integrate mental health screening, assessment, and basic clinical interventions with primary health care delivery is one of the most pressing service system issue for elderly Americans with mental health problems.

- The *HIV/AIDS Treatment Adherence/Health Outcome and Cost Study* reflects the collaboration of six Federal entities**C**the Center for Mental Health Services, which has lead administrative responsibility, and the Center for Substance Abuse Treatment, both of which are components of the Substance Abuse and Mental Health Services Administration (SAMHSA); the HIV/AIDS Bureau in the Health Resources and Services Administration (HRSA); and the National Institute of Mental Health, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse, all of the National Institutes of Health (NIH). The HIV/AIDS Cost Study is the first-ever Federal initiative designed to study integrated mental health, substance use, and primary medical HIV treatment interventions. More importantly, the study is the first Federal effort to determine if an integrated approach to care improves treatment adherence, produces better health outcomes, and reduces the overall costs associated with HIV treatment.

- The *HIV/AIDS High-Risk Behavior Prevention/Intervention Model for Young*

Adults/Adolescents and Women Program is a collaborative venture aimed at bringing AIDS prevention into the community. Project SHIELD also represents an opportunity to move the field of HIV prevention research forward along the two parallel continuum of innovative intervention design and rigorous evaluation. The multisite nature of this HIV prevention trial has the potential to test the efficacy of two brief interventions and generalize the study results to more than one study population. In essence, the question posed by Project SHIELD is: can the principles underlying demonstrably effective HIV prevention interventions be applied in brief formats to real world client sand still be effective in reducing HIV risk behaviors? Although the HIV prevention field has traditionally relied on self reports of risk behaviors as the primary outcome Project SHIELD will not only measure participants= self reported behavior change, which may be biased, but will *actually* measure reductions in diseases; diseases such as common STDs that are associated with considerable adverse sequelae and may facilitate HIV transmission.

C The *Supported Housing Study* was designed to enhance knowledge about how different housing approaches contribute to the rehabilitation and recovery of individuals with serious mental illness, using individual study sites and a coordinating center. In particular, it evaluates the effectiveness of the supported housing model. A two-phase study, the sites will each implement supported housing as well as one other housing intervention. The initial phase involves a process evaluation of the implementation, the latter phase will include both within-site and cross-site outcome evaluations.

C The *Jail Diversion Study* addresses a services priority: diversion of individuals with severe mental illness and substance abuse disorders from the criminal justice system to community treatment alternatives. Together with CSAT, CMHS seeks to provide an empirical basis for understanding the effectiveness of pre-booking and post-booking models of criminal justice diversion in improving selected outcomes for individuals with co-occurring disorders who are alleged to have been involved in criminal activity. The primary outcomes to be assessed include but are not limited to: criminal recidivism, time incarcerated, psychiatric hospitalization, psychiatric status, functional status, continuity of participation in treatment, homelessness, emergency treatment utilization, and reduction of frequency of substance abuse.

C The *Women and Trauma Study* will look at women with histories of violence and co-occurring mental health and substance abuse disorders. Women with this cluster of concerns seem to have greater utilization of services and longer inpatient stays. Children of this target population are also at greater risk for developing emotional problems. Yet, the treatment systems that deal with these different types of problems are typically organized separately and independently.

The literature clearly shows that the violence-related problems of women with co-occurring disorders and the consequences on their children have not been adequately addressed. This study, with 11 sites plus a Coordinating Center, will examine strategies for the integration of treatment interventions for this target population of women and their children. It will also consider the integration of different systems that have historically offered compartmentalized treatment to women for one or more of these problems. This study will develop new knowledge about the feasibility and efficacy of treating these mental health, substance abuse, and trauma disorders

simultaneously in an integrated intervention, keeping in mind the needs of both the women consumers and their children.

- The *Homeless Families with Children Program* examines strategies to provide treatment, housing, support, and family preservation services to adults with psychiatric and/or substance use disorders and their children. The program investigates the extent to which these interventions are effective and will be conducted in three phases: clarification and strengthening the intervention, an outcome evaluation of the effectiveness of the intervention, and a dissemination phase. Because families are the fastest growing segment of the homeless population, identifying and disseminating effective interventions for adults and children who are homeless or at-risk for homelessness has become critical.

- The *Child Treatment Effectiveness* initiative, a collaboration between CMHS and NIMH, is developing a standardized treatment package for specific childhood disorders that can be field tested in community settings. This multi-phased project began in FY 1998; field trials are slated to begin at the end of FY 1999. If found to be effective, these models will be disseminated for adoption in the last phase of the program.

- CMHS is initiating a new *Youth Transition Study* The transition period for youth and young adults with emotional/behavioral disturbances presents unique barriers that put these individuals at significantly greater risk for school failure, involvement with the criminal justice system and/or dependency on social services. These youth have the highest rates of dropout from secondary school and experience the poorest outcomes in later employment, arrests, incarceration, and independent living. The transition period for youth and young adults with emotional/behavioral disorders is further complicated by the lack of coordinated services among the children=s mental health, child welfare, education, adult mental health, substance abuse treatment, and rehabilitation sectors. The resulting poor outcomes for this population also present extreme costs in at least three major areas: a) individuals and families; b) the security of the community; and, c) local, state, and federal government.

  The knowledge development activity proposed here will begin to test the effectiveness of identified innovative strategies which indicate promise in successfully linking child and adult systems of care to provide positive outcomes for this population.

Knowledge Application Accomplishments

In FY 1999, CMHS is developing improved methods to synthesize and disseminate to the field comprehensive summaries of best practices in selected topic areas that can simplify the translation of knowledge gained into program practice by practitioners working at the local level. Examples of current knowledge synthesis accomplishments follow.

Co-Occurring Disorders Service Improvement Framework: Recognizing the growing evidence that service coordination is a key element of effective service delivery for persons with co-occurring mental health and substance abuse services, SAMHSA supported a National Dialogue on Co-Occurring Mental

Health and Substance Abuse disorders in June, 1998. The dialogue was sponsored by NASMHPD and NASADAD and involved six State Commissioners/Directors of Mental Health and six State Substance Abuse Directors. The dialogue produced a conceptual framework that represents a new paradigm for considering both the needs of individuals with co-occurring disorders and the service system requirements designed to address these needs. It provides for defining co-occurring disorders in severity terms rather than specific diagnoses, thereby encompassing the full range of people who have co-occurring mental health and substance abuse disorders and for focusing on coordination of services for all persons with co-occurring disorders regardless of severity of illness. For those persons with severe disorders, integrated services is necessary. The dialogue has already spurred much policy deliberation in the States and will be continued by the NASADAD and NASMHPD directors at the national level during FY 1999.

National Dialogue on the Implications of the Homeless Study=s Findings for the States: CMHS has again partnered with NASMHPD to synthesize the current findings of the ACCESS Study and related findings elsewhere in the field, to identify those findings with greatest implications for state mental health directors, present the findings to representative directors for policy deliberation and development of action recommendations to all directors in the summer of FY 1999.

Services Information for State Planning and Advisory Council Members: CMHS has commissioned the National Association of Mental Health Planning and Advisory Council members to develop brochures that describe innovative services which should be the subject of State mental health planning activity and to perform a series of follow-up activities designed to give Planning and Advisory Council members ongoing support in using this innovative service information during their deliberations. Consistent with current knowledge development activity, this year=s topics are Assertive Community Treatment and service to the homeless. The Initiative replaces the AInnovation Packets@ initiative from last year as CMHS effort to link KDA with the planning activities mandated under the Block Grant program. It takes advantage of advice and comments from last year=s customers on improving the process.

Assessment of the Evidence Base for the Systems Integration Approach to Serving Persons with Serious Mental Illness: Many of CMHS= studies focus on improving service coordination for persons with serious mental illness who have different problems that affect the quality of their lives negatively. For the first time ever, CMHS brought together teams of researchers, consumers and program providers from all CMHS=s KDA programs to discuss how their individual findings compliment or contradict those of the other programs. While no conclusions were reached, the process was very productive and gives CMHS further directions on next steps to take in formulating an overall strategy for improving service delivery by creating better integration among the multiplicity of agencies serving this needy group of very high-end consumers of public services.

Model Program Standards for the Program for Assertive Community Treatment (PACT): Having supported development of standards and guidelines for evidence-based assertive community treatment (ACT), CMHS has entered a partnership with HCFA to foster use of evidence-based assertive community treatment in States that have not already adopted the practice. Discussions concern distribution by HCFA of descriptions of ACT minimum practice standards, models of appropriate Medicaid funding mechanisms and, possibly, encouragement by the Medicaid Bureau Director that all states encourage and fund the

practice.

Survey of Supported Employment Study Findings: The results of a completed CMHS study on Supported Employment were recently published in the Summer 1998 issue of *Psychiatric Rehabilitation Journal*. This study, conducted through Dartmouth University, showed that a supported employment intervention had persistent positive effects on the competitive employment and satisfaction with vocational rehabilitation services of persons with SMI. It is notable that such improvements were attained at no extra cost relative to traditional vocational rehabilitation services. Other issues discussed in the special volume include: job preferences, ethnocultural factors, co-occurring disorders, and cost-effectiveness implications for managed care.

Adoption of Exemplary Practices

In addition to information synthesis and dissemination, CMHS is expanding efforts to support the adoption of exemplary practices in mental health service delivery in communities throughout the Nation. Examples include:

Community Action Grants

The Community Action Grant Program (CAG) was initiated in FY 1997. The goals of the program are to: 1) identify exemplary practices, build consensus for the adoption of the exemplary practice and then provide technical assistance for eventual adoption and implementation of the exemplary practice into the systems of care; (2) improve technology transfer efforts to increase interaction among users and producers of knowledge and help them use that knowledge to improve mental health systems; and (3) synthesize and disseminate new knowledge about effective approaches to providing comprehensive community-based services to persons with severe mental illnesses. The target population for this program includes two subgroups: adults with severe mental illness and children/adolescents with serious emotional disturbances and their families.

In FY 1998, additional funds from each of the three SAMHSA Centers were offered to encourage the identification and adoption of exemplary practices in Hispanic communities. The goal of this incentive was not only to recognize, but to actively address, the unique mental health and substance abuse prevention/treatment needs of Hispanic Americans. A second round of 31 CAG grants started in September 1998. Eleven of the 31 grants focus on Hispanic communities. CAGs identify exemplary practice models that meet objective, evidenced-based criteria and support consensus building among key stakeholders to adopt the exemplary practice. Information about these approved exemplary practices is then made available to new sponsors of exemplary practices in other communities. Among those practices being implemented by new grantees are: employment models, assertive community treatment, integrated mental health/substance abuse services, a gatekeeper model for elderly, substance abuse programs, family support and education, substance abuse prevention and children=s Awrap around@ services. Additionally, CMHS=s Community Action Grants are dispersed throughout the country. For example,

- *Consumer Leadership Academy*: In Massachusetts and North Carolina, consumer organizations are taking the lead in building consensus for programs providing leadership skills to mental health consumers.

- *Homeless Mobile Outreach*: A collaborative initiative among agencies in Contra Costa County, Napa Valley, and San Jose, California is working to implement an exemplary practice to conduct outreach to homeless persons with severe mental illness and co-occurring substance abuse problems.

- *Jail Diversion*: Projects in South Carolina and Texas will build consensus among the criminal justice, mental health and substance abuse systems to develop diversion programs for individuals with mental illness and substance abuse problems. The Texas program will target the Hispanic community.

The CAG program contributes to the achievement of Goal 2-- Promote the Adoption of Best Practices. See GPRA plan for standard measures and program specific measures. Preliminary data are not yet available for this program.

The Employment for Persons with Disabilities Initiative: CMHS and SSA have entered into a partnership to fund States wishing to pilot mechanisms which eliminate barriers to employment for persons with disabilities, including mental disabilities. In September, 1998, demonstration grants were awarded to 12 States; 9 of the 12 grants were to States conducting special projects involving individuals with a serious mental illness. In addition Center staff met with the Program Coordinating Center to formulate a technical assistance and monitoring approach to the Program that will improve both the project results and dissemination of those results to the field.

Knowledge Exchange Network: CMHS continues to expand the technical capacity of its *Knowledge Exchange Network (KEN)* initiated in FY 1995. KEN operates a clearinghouse designed to assure the widespread dissemination of information to support the work of all CMHS programs as they seek to improve the delivery of mental health services. The KEN clearinghouse and electronic bulletin board system are supported by technical assistance centers with expertise in special population and program issues.

KEN contributes to the achievement of Goal 2-- Promote the Adoption of Best Practices. See GPRA plan for standard measures and program specific measures, and update data.

Minority Fellowship Program: As part of its continuing effort to foster minority leadership in mental health services, CMHS collaborates with CSAT and CSAP to fund the *Minority Fellowship Program (MFP)*, which provides doctoral-level training to increase the pool of professionals qualified to provide leadership, consultation, training and administration to governmental health agencies and public and private organizations concerned with the development and implementation of programs and services for underserved ethnic minority persons with mental and/or substance use disorders.

HIV/AIDS Mental Health Provider Education Program: The *HIV/AIDS* Mental Health Care Provider Education Program completed its final year of funding in FY 1998. Grants have been awarded in the Mental Health Provider Education in *HIV/AIDS* Program II to evaluate the dissemination of knowledge on (1) the psychological and neuropsychiatric sequelae of HIV/AIDS, and (2) the ethical issues in providing services to people with HIV/AIDS, to both traditional and nontraditional first-line providers of mental health services, and to evaluate the relative effectiveness of different education approaches. Training approaches are incorporating the most current research-based information and allow easy modifications to reflect changes in the medical regimen for treatment of AIDS.

Funding levels for the past five fiscal years were as follows:

	Funding	FTE
1995	$52,216,000	---
1996	38,032,000	---
1997	57,964,000	---
1998	57,964,000	---
1999	97,964,000	---

Rationale for the Budget Request

The FY 2000 Budget Request proposes to maintain in the KDA Program at the FY 1999 appropriation level.

New activity in FY 2000 is designed to improve the application of existing knowledge; i.e. translating science into services. New initiatives will take advantage of an array of cutting-edge strategies for supporting the Nation=s agents of service system improvement, including consumers, families, state and county governments, as well as a wide variety of public agencies. The specific programs will not only provide communities the information they need about exemplary mental health practices but also provide them with the special tools they will need to make change happen. These tools include methods for engaging decision makers, building consensus, overcoming implementation barriers, using strategic planning effectively, team building, and networking. Perhaps most importantly, CMHS seeks to place consumers, families and consumer supporters in a position to act as change agents on their own behalf in their own communities. The following activities are representative of those to be funded under the Initiative.

- Expansion of Community Action Grants for Service System Change: The Community Action Grant program has been effective in building consensus to implement a variety of exemplary intervention practices in a variety of settings. Within this new round of Community Action Grants, CMHS will pilot an enhanced evaluation mechanism for a subset of 10 projects to allow providers of mental health services to use their quality improvement capacity to contribute to measuring consensus building, program fidelity, and planning for outcome measurement. A portion of the expanded effect will be used to support increased quality improvement capacity to achieve these goals.

- Providing Systems Change Support: CMHS will develop a Strategic Change Program (SCP) that fosters partnering among States and community agencies; uses strategic planning to support systems change; and provides assistance to States in tracking other social service policy issues relevant to mental health consumers. The SCP will operate as a training institute and coordinating center for strategic planning and implementation targeted to Communities and States. The SCP will only engage in activities where interagency partnerships are necessary to accomplish specific service delivery systems changes targeting carefully identified populations of persons with mental illness or children with serious emotional disturbances.

- Establish Peer-to-Peer Technical Assistance Networks: Under this project, CMHS will improve federal technical assistance by establishing peer-to-peer technical assistance networks, linking CMHS=s services research grantees with communities seeking to improve service and other methods of expanding mutual support within the field. This component of the initiative acknowledges that CMHS has neither the resources nor the expertise to provide all the technical assistance the field needs to accomplish implementation of emerging exemplary practices. Instead CMHS will link experts -- by both learning and experience -- with individuals who are need technical assistance. Peer-to-peer networks will be used to match persons in need with those to whom they can best relate (their peers) who have needed information and expertise. In particular, CMHS will seek to take advantage of the huge body of expertise represented by its own grantees and, again, link that expertise with communities that want to improve services.

- Employment for Persons with Disabilities: Inter-Agency Task Force Initiatives: In addition to the Disability Initiative being taken with SSA described above, CMHS will also support activities of the National Task Force on Employment of Adults with Disabilities and its member agencies to ensure that the many activities designed to increase employment opportunities for persons with disabilities include specific attention to those who have mental disabilities. CMHS will leverage resources dedicated to the entire disability community to the specific needs of persons with mental problems, eliminating duplication and redundancy as well as increasing the opportunities to explore how lessons learned about employment for persons with any disability can be applied to those with specific mental disabilities.

- A Continuum of Care Project: A new Continuum of Care program will examine the extent to which mental health services improve the utilization of all health and human services, improve health and social outcomes, and improve the outcomes of the next generation of children by preventing behaviors that increase risk of contracting HIV/AIDS. The program will seek to increase compliance with medical regimens as well as mental health and substance abuse treatment, reduce risky behaviors, improve life outcomes for children affected by HIV/AIDS, and inform the field of effective models of service and models for integration of services and evaluation that can be replicated.

- A Bioterrorism Initiative focuses on preparedness for the psychosocial and emotional ramifications of terrorist threats and events. The expert field that would permit a scientifically driven response plan to the behavioral and psychosocial consequences of Bioterrorism does not currently exist. Despite the critical necessity and reality of instituting plans, the field needs to be developed and driven to explore the knowledge and activities that will serve to guide state and local planning.

- CMHS=s primary role in the National Agenda Against Underage Drinking will be related to the generation of new empirical knowledge about what brief intervention and treatment models and associated services are most effective for brief intervention or treatment of mental health problems and conditions in the cited underage populations.

- Violence Against Women is also a new cross-cutting initiative that seeks to discover what works

to improve women=s outcomes in the utilization of substance abuse and mental health treatment services and to promote the improved coordination of services by developing an integrated service delivery system. CMHS will work with CSAP and CSAT to provide training for health care professionals and students in medical school or other health professions educational institutions. Additionally, CMHS will work collaboratively to expand current assessment and evaluation programs to assess the effectiveness of substance abuse/mental health treatment programs in addressing health consequences of domestic and sexual violence.

B. CENTER FOR MENTAL HEALTH SERVICES
2. Children=s Mental Health Services Program

Authorizing Legislation - New legislation has been submitted.

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA.....	$72,927,000	$78,000,000	$78,000,000	---
2000 Authorization				
PHSA Section 565 (f) .....Indefinite				

Purpose and Method of Operation

The Comprehensive Community Mental Health Services for Children and Their Families Program was implemented in FY 1993 to encourage the development of intensive community-based services for children with serious emotional disturbances and their families based on a multi-agency, multi-disciplinary approach involving both the public and private sectors. The target population for these grants is children and adolescents, from birth to 18 years of age (unless specifically extended by States to persons less than 22), with a diagnosable serious emotional, behavioral, or mental disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV and that results in a functional impairment which substantially interferes or limits the child=s role or functioning in family, school, or community activities.

Funds are available to States, political subdivisions of States, territories, and Indian tribes or tribal organizations. Funds are used to build on the existing service infrastructure so that the array of services required to meet the needs of the target population is available and accessible. Grants are limited to a total of 5 years and grantees must develop sources of non-federal matching contributions which must increase over the term of the award from $1 for each $3 of Federal funds in the first year to $2 for each $1 of Federal funds in the final year.

The goals of the Program are to:

- expand the service capacity in communities that have developed an infrastructure for a culturally competent, community-based, coordinated, interagency approach to serving children and adolescents in the target population and their families;

- provide a broad array of mental health services and supports that are community-based, family-centered and tailored to meet the needs of the child or adolescent through an individualized service planning process; and

- ensure an expanded role for families which includes full involvement in the development of local services and supports for their children.

Evaluation: The program, a leader in interagency collaboration, was recently recognized with Vice President Gore=s Hammer Award, highlighting the accomplishments of an interagency team formed by CMHS to consolidate training and technical assistance from several agencies into a single comprehensive effort.

The ongoing national multisite evaluation of the 45 children=s services projects assesses outcomes for children and their families as well as the development of a service system. The evaluation focuses on assessing children and families, the service system, and the interaction between the two. Descriptive information is obtained on the characteristics of all children and families that enter the service program. In addition, each grant site has a goal of gathering outcome information on a sample of at least 200 children and their families. Based on data collected through May, 1998, using an OMB-approved set of measures, descriptive baseline information was available on over 25,500 children, and six-month functional outcomes were available on over 3,300 children.

Child and Family Characteristics. Among the children entering the service sites, 63% were male, 37% were female. The children=s average age was 12.6 years. White children represented 54% of service recipients, while 22% were Hispanic, 17% were African American, and 7% were classified as Native Americans, Native Hawaiians, or Asian/Pacific Islanders. Among those children assigned a primary diagnosis, 35% had conduct or adjustment disorders, 26% had depressive or dysthymic disorders, 13% had attention deficit or hyperactivity disorders, 7% had anxiety disorders, and 2% had psychotic disorders. The remaining 17% of the children were diagnosed with substance use, developmental disorders, learning disability, other, or, the primary diagnosis was deferred. With respect to family characteristics, children in custody of their mothers represented 48% of the sample, compared to a national average for mother-maintained households of 27%.

Child Outcomes at Six Months. Findings show notable improvements for children after six months in service.

- ***Law Enforcement Contacts Reduced.*** No law enforcement contacts were reported for 44% of the children who had one or more contacts in the 12 months before entering services.

- ***School Grades Improve.*** The percentage of children with average or above average school grades increased by 14%.

- ***Fewer School Absences.*** The percentage of children attending school half or less of the time decreased by 33%.

- ***Mental Health Improves.*** The percentage of children with marked or severe levels of functional impairment was reduced by 33%.

- ***Stable Living Arrangements Increase.*** A single living arrangement was reported for 50% of the children who reported multiple living arrangements in the 12 months before entering services.

A growing source of evidence about the positive changes taking place in children=s service systems is the

individual grantee sites which have expanded their evaluations beyond the requirements of the national multisite evaluation. Site-specific findings include:

- ***Money Saved.*** In Milwaukee, Wisconsin, the average monthly cost of caring for a child in the Wraparound Program was $2,800. That was 37% less than the average monthly cost of $4,449 of serving a child in a typical out-of-home residential placement.

- ***Fewer Crimes Committed.*** Based on a two-year study, the Crossroads Program of San Mateo, California, reported a 61% reduction in the number of crimes committed by youth in probation during the 12 months after entering the program compared to the 12 months before entering the program.

- ***Acute Psychiatric Hospitalizations Reduced.*** The program in Sonoma County, California, reported that the average number of acute psychiatric hospitalizations per month among children and youth during 1995 and 1996 was reduced by 34% during 1997. These reductions represented a 48% cost savings.

- ***Children Stay in Their Communities.*** The ACCESS Program in Alexandria, Virginia, showed a 48% reduction in out-of-city residential placements for children with serious emotional disturbance since the program=s inception in 1995.

The experience of administering the Comprehensive Community Mental Health Services for Children and Their Families Program over the past five years also has generated important lessons about method:

- **The contribution of specific clinical treatment interventions to the service system as a whole must be examined as part of determining treatment effectiveness.** The development of effective treatment interventions within service systems must receive as much attention as the development of integration and coordination mechanisms of the service system. Specific quality treatments delivered to children and families in the context of a service system may prove to have a greater impact on child and family outcomes than the service system as a whole. The proposed Treatment Effectiveness Study program under KDA will accomplish this goal. The partnership between this Program and KDA programs strengthens both and provides the best opportunity for evolving increasingly effective services for children and their families.

- **Accountability to families must be included among expected outcomes for effective services.** Children and families who receive services are increasingly demanding that service systems be held accountable to deliver services that meet their needs. Service systems must find ways to increase the involvement of family members in the delivery, management, and evaluation of services. Satisfaction is a key outcome studied in the national evaluation.

- **New evaluation and information system tools must be developed to accommodate Arealworld@ or field conditions as well as the expectations of both customers andresearchers.** Calls for accountability of the service system to the service community require the development of new evaluation methodologies that provide meaningful and timely information about service quality.

A critical tool for these new methodologies will be an information system that integrates data effectively and efficiently from collaborating human service agencies. Development of an efficient cross-agency information management system is a key element of infrastructure development under the Program.

- **Managed care practices must be included in any service study.** Service systems must become cost effective, especially when resources are limited. The degree to which service systems adopt managed care practices may very well determine the ability of the systems to deliver much needed services to children and families. Beginning in FY 1998, all new grants are required to address the important relationship between grant programs and managed care practices in the target jurisdiction.

- **Population-based measurement of service impact is needed.** The impact of service systems across the Nation will be largely understood by the degree to which services reduce the mental health needs of children and their families in the general population. Population-based accountability tools will need to be increasingly applied to demonstrate service penetration and its resulting needs reduction. The national evaluation includes development of population-based measurement tools that will measure the extent to which client level outcomes can be generalized to the general population.

Still more can be learned about the specific effects of systems of care. Three grantee sites with mature systems of care were selected to participate in a study to compare their child, family, and system outcomes with the outcomes of non-grantee sites that deliver services as usual. Geographic, demographic, and economic criteria were used to match non-grantee sites with grantee sites. Results of this Comparison Study, which are expected to be reported in the legislatively mandated report to Congress for FY 1999. This report, to be submitted summer FY 1999, will provide critical information on the characteristics of system of care sites that yield better child, family, and system outcomes than sites delivering services as usual.

The Children=s Mental Health Services Program contributes to the achievement of Goal 3--Assure Services Availability/Meet Targeted Needs. See GPRA plan for standard measures and program specific measures, and update data.

Funding levels for the past five fiscal years were as follows:

	Funding	FTE	
1995	$58,958,000	---	1996
	59,927,000	---	
1997	69,896,000	---	
1998	72,927,000	---	
1999	78,000,000	---	

Rationale for the Budget Request

The FY 2000 President=s Budget proposes a funding level for the Comprehensive Mental Health Services for Children and Their Families program of $78,000,000. This funding level is the same as FY 1999 and will allow the program to continue supporting approximately 51 grants, and will allow continued evaluation of the program in addressing key goals.

B. CENTER FOR MENTAL HEALTH SERVICES
3. Protection and Advocacy Program (P&A)

Authorizing Legislation - New legislation has been submitted.

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA.....	$21,957,000	$22,957,000	$22,957,000	---

2000 Authorization

P.L. 102-173, Section 117.....Expired

Purpose and Method of Operation

The Protection and Advocacy Program for Individuals with Mental Illness Act (PAIMI) authorizes formula grant allotments to be awarded to Protection and Advocacy (P&A) systems that have been designated by the Governor in each of the 50 States, the District of Columbia, and the U.S. Territories. The State P&A programs are mandated to protect the rights of and advocate for the individuals with mental illness and severe emotional disturbance. The allotments are used to investigate allegations of abuse and neglect in public and private facilities such as hospitals, nursing homes, community facilities, board and care homes, homeless shelters, jails and prisons, etc., that care for or treat individuals with mental illness. P&A programs address problems which arise during transport and admission to the institutions, as well as the time of residency in, and 90 days after discharge from them. The P&A systems also pursue legal, administrative and other appropriate remedies to redress complaints of abuse, neglect, and rights violations through activities that ensure the enforcement of the Constitution and Federal and State statutes and regulations. They also are mandated to ensure protection and advocacy for the rights of persons with mental illness.

The most recent data (FY 1997) indicate that PAIMI programs responded to more than 23,000 abuse, neglect and civil rights violations. By utilizing combinations of technical assistance, administrative remedies, negotiation and mediation, the majority of these complaints were resolved. Only 4 percent of the total complaints received needed legal intervention. In addition, PAIMI programs were involved in the following activities: representing approximately 285,636 individuals in class action suits; advocating on behalf of 405 groups (including nearly 1,334,226 persons), e.g., hospital wards and consumer organizations; responding to 62,151 requests for information; and conducting education and training sessions for 73,107 mental health administrators, legislators, P&A staff, other community organizations and mental health system clients and their families.

The Protection and Advocacy Program (P&A) contributes to the achievement of Goal 3--Assure Services Availability/Meet Targeted Needs. See GPRA plan for standard measures and program specific measures, and update data.

Funding levels for the past five fiscal years were as follows:

	Funding	FTE
1995	$21,957,000	---
1996	19,850,000	---
1997	21,957,000	---
1998	21,957,000	---
1999	22,957,000	---

Rationale for the Budget Request

The FY 2000 President=s budget proposes to fund the Protection and Advocacy Program at $22,957,000. This funding will allow the program to maintain its activities at the FY 1999 enacted level.

Center for Mental Health Services
Protection & Advocacy Program

State/Territory	FY 1998 Actual	FY 1999 Appropriation	FY 2000 Estimate	Difference +/- 2000 vs 1999
Alabama	$292,440	$307,385	$307,385	---
Alaska	259,782	271,613	271,613	---
Arizona	293,898	314,590	314,590	---
Arkansas	259,782	271,613	271,613	---
California	1,943,380	2,041,368	2,041,368	---
Colorado	259,782	271,613	271,613	---
Connecticut	259,782	271,613	271,613	---
Delaware	259,782	271,613	271,613	---
District of Columbia	259,782	271,613	271,613	---
Florida	897,741	951,267	951,267	---
Georgia	471,288	495,779	495,779	---
Hawaii	259,782	271,613	271,613	---
Idaho	259,782	271,613	271,613	---
Illinois	703,778	731,471	731,471	---
Indiana	375,684	393,073	393,073	---
Iowa	259,782	271,613	271,613	---
Kansas	259,782	271,613	271,613	---
Kentucky	268,843	280,610	280,610	---
Louisiana	300,729	311,827	311,827	---
Maine	259,782	271,613	271,613	---
Maryland	296,184	309,207	309,207	---
Massachusetts	346,002	358,432	358,432	---
Michigan	588,331	629,518	629,518	---
Minnesota	283,885	296,176	296,176	---
Mississippi	259,782	271,613	271,613	---
Missouri	342,993	359,193	359,193	---
Montana	259,782	271,613	271,613	---
Nebraska	259,782	271,613	271,613	---
Nevada	259,782	271,613	271,613	---
New Hampshire	259,782	271,613	271,613	---
New Jersey	441,871	463,140	463,140	---
New Mexico	259,782	271,613	271,613	---
New York	1,040,100	1,072,815	1,072,815	---
North Carolina	477,566	500,214	500,214	---
North Dakota	259,782	271,613	271,613	---

Center for Mental Health Services
Protection & Advocacy Program

State/Territory	FY 1998 Actual	FY 1999 Appropriation	FY 2000 Estimate	Difference +/- 2000 vs 1999
Ohio	**706,422**	**735,314**	**735,314**	**---**
Oklahoma	**259,782**	**271,613**	**271,613**	**---**
Oregon	**259,782**	**271,613**	**271,613**	**---**
Pennsylvania	**743,339**	**768,827**	**768,827**	**---**
Rhode Island	**259,782**	**271,613**	**271,613**	**---**
South Carolina	**259,782**	**271,613**	**271,613**	**---**
South Dakota	**259,782**	**271,613**	**271,613**	**---**
Tennessee	**346,995**	**363,170**	**363,170**	**---**
Texas	**1,242,120**	**1,299,717**	**1,299,717**	**---**
Utah	**259,782**	**271,613**	**271,613**	**---**
Vermont	**259,782**	**271,613**	**271,613**	**---**
Virginia	**407,025**	**426,026**	**426,026**	**---**
Washington	**338,921**	**355,198**	**355,198**	**---**
West Virginia	**259,782**	**271,613**	**271,613**	**---**
Wisconsin	**327,414**	**340,093**	**340,093**	**---**
Wyoming	**259,782**	**271,613**	**271,613**	**---**
Puerto Rico	**469,828**	**477,560**	**477,560**	**---**
American Somoa	**139,242**	**145,584**	**145,584**	**---**
Guam	**139,242**	**145,584**	**145,584**	**---**
North Mariana Islands	**139,242**	**145,584**	**145,584**	**---**
Virgin Islands	**139,242**	**145,584**	**145,584**	**---**
TOTAL, States &Territories....	**21,517,859**	**22,497,857**	**22,497,857**	**---**
Set-Aside.....	**439,141**	**459,143**	**459,143**	**---**
TOTAL P&A.....	**$21,957,000**	**$22,957,000**	**$22,957,000**	**---**

B. CENTER FOR MENTAL HEALTH SERVICES
4. Projects for Assistance in Transition from Homelessness (PATH)

Authorizing Legislation - New legislation has been submitted.

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA.....	$23,000,000	$26,000,000	$31,000,000	+$5,000,000

2000 Authorization

PHSA Section 535 (a).....Expired

Purpose and Method of Operation

The Projects for Assistance in Transition from Homelessness (PATH) program was established in FY 1991 as a formula grant program to distribute Federal funds to each State, the District of Columbia, and the U. S. Territories to provide services to individuals with severe mental illness, as well as to individuals with severe mental illness and co-occurring substance abuse disorders, who are homeless or at risk of becoming homeless. Eligible services funded include: outreach; screening and diagnostic treatment; habilitation and rehabilitation; community mental health services; alcohol or drug treatment (for mentally ill individuals with co-occurring substance use disorders); staff training; case management; supportive and supervisory services in residential settings; and referrals for primary health care, job training, and education. In addition, to improve coordination of services and housing for the target population, a limited set of housing services may be funded.

PATH delegates to States responsibility to determine their own priorities from among the wide array of eligible services. Under PATH, States are encouraged to develop and implement outcome measures and have considerable flexibility to determine goals, objectives and outcomes. The PATH program requires matching funds of $1 to every $3 of federal funds. In 1996, State and local matching funds were more than twice as much as the required amount.

The PATH program contributes to, and benefits from, the CMHS: Knowledge Development and Application strategy. PATH funded programs serve both as sources and recipients of knowledge concerning exemplary practices in the delivery of mental health services for the homeless.

Clients Served: The most recent program data indicate that in FY 1996, 380 local agencies and/or counties received PATH funding. A total of 76,000 clients were served, with adults in the age range 18-64 comprising 93 percent of the caseloads. Of the clients served, 40 percent were African-American; 8 percent were of Hispanic origin. Persons receiving PATH-funded services have some of the most disabling mental disorders. For the States reporting diagnostic information, the most common diagnoses were affective disorders (37 percent), followed by schizophrenia and other psychotic disorders (34 percent). Sixty six percent of clients served had a co-occurring substance use disorder in addition to a serious mental

illness.

The Projects for Assistance in Transition from Homelessness (PATH) Program contributes to the achievement of Goal 3--Assure Services Availability/Meet Targeted Needs. See GPRA plan for standard measures and program specific measures, and update data.

Funding levels for the past five fiscal years were as follows:

	Funding	FTE
1995	$29,462,000	---
1996	20,000,000	---
1997	20,000,000	---
1998	23,000,000	---
1999	26,000,000	---

Rationale for the Budget Request

The proposed funding for this program in FY 2000 is $31 million, an increase of $5 million (19%) over the FY 1999 appropriation. States will use these resources to provide additional outreach services and to enroll more people into mainstream services. For FY 2000 PATH expects to: increase the number of persons contacted from 102,000 to 115,000; improve targeting of services to those most in need; and increase the percentage of persons contacted who become enrolled clients from 30% to at least 33%, and increase the number of participating agencies that offer outreach services from 70% to 80%.

Center for Mental Health Services
PATH Program

State or Territory	FY 1998 Actual	FY 1999 Appropriation	FY 2000 Estimate	Difference +/- 2000 vs 1999
Alabama	$300,000	$300,000	$300,000	---
Alaska	300,000	300,000	300,000	---
Arizona	300,000	314,000	409,000	95,000
Arkansas	300,000	300,000	300,000	---
California	2,381,000	3,015,000	3,920,000	905,000
Colorado	300,000	300,000	366,000	66,000
Connecticut	300,000	300,000	378,000	78,000
Delaware	300,000	300,000	300,000	---
District of Columbia	300,000	300,000	300,000	---
Florida	952,000	1,205,000	1,567,000	362,000
Georgia	305,000	386,000	502,000	116,000
Hawaii	300,000	300,000	300,000	---
Idaho	300,000	300,000	300,000	---
Illinois	793,000	1,004,000	1,305,000	301,000
Indiana	300,000	319,000	415,000	96,000
Iowa	300,000	300,000	300,000	---
Kansas	300,000	300,000	300,000	---
Kentucky	300,000	300,000	300,000	---
Louisiana	300,000	300,000	343,000	43,000
Maine	300,000	300,000	300,000	---
Maryland	335,000	424,000	551,000	127,000
Massachusetts	442,000	560,000	728,000	168,000
Michigan	544,000	688,000	895,000	207,000
Minnesota	300,000	300,000	365,000	65,000
Mississippi	300,000	300,000	300,000	---
Missouri	300,000	329,000	428,000	99,000
Montana	300,000	300,000	300,000	---
Nebraska	300,000	300,000	300,000	---
Nevada	300,000	300,000	300,000	---
New Hampshire	300,000	300,000	300,000	---
New Jersey	620,000	785,000	1,021,000	236,000
New Mexico	300,000	300,000	300,000	---
New York	1,320,000	1,671,000	2,173,000	502,000
North Carolina	300,000	300,000	387,000	87,000
North Dakota	300,000	300,000	300,000	---

Center for Mental Health Services
PATH Program

State or Territory	FY 1998 Actual	FY 1999 Appropriation	FY 2000 Estimate	Difference +/- 2000 vs 1999
Ohio	622,000	788,000	1,025,000	237,000
Oklahoma	300,000	300,000	300,000	---
Oregon	300,000	300,000	300,000	---
Pennsylvania	674,000	853,000	1,110,000	257,000
Rhode Island	300,000	300,000	300,000	---
South Carolina	300,000	300,000	300,000	---
South Dakota	300,000	300,000	300,000	---
Tennessee	300,000	300,000	341,000	41,000
Texas	1,063,000	1,346,000	1,751,000	405,000
Utah	300,000	300,000	300,000	---
Vermont	300,000	300,000	300,000	---
Virginia	358,000	453,000	590,000	137,000
Washington	301,000	381,000	495,000	114,000
West Virginia	300,000	300,000	300,000	---
Wisconsin	300,000	300,000	379,000	79,000
Wyoming	300,000	300,000	300,000	---
Puerto Rico	300,000	300,000	327,000	27,000
American Somoa	50,000	50,000	50,000	---
Guam	50,000	50,000	50,000	---
North Mariana Islands	50,000	50,000	50,000	---
Virgin Islands	50,000	50,000	50,000	---
Total, States & Territories	22,310,000	25,221,000	30,071,000	4,850,000
Set-Aside	690,000	779,000	929,000	150,000
TOTAL, PATH	$23,000,000	$26,000,000	$31,000,000	$5,000,000

B. CENTER FOR MENTAL HEALTH SERVICES
5. Mental Health Block Grant (MHBG)

Authorizing Legislation - New legislation has been submitted.

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA.....	$275,420,000	$288,816,000	$358,816,000	+$70,000,000

2000 Authorization

Mental Health Block Grant .....Expired

Purpose and Method of Operation

The Mental Health Block Grant (MHBG) supports comprehensive, community-based systems of care for adults with a serious mental illness (SMI) and children with serious emotional disturbances (SED). Grants are awarded to States and Territories based on a legislated formula (described below). States are required to develop annual plans with input from State Planning Councils and must include goals, objectives, and performance indicators. This process enables States to better meet the unique needs of their SMI and SED populations. Examples of populations served by Block Grant supported community-based programs include, but are not limited to:

Adults with severe mental illness

(1) who have a history of repeated psychiatric hospitalizations or repeated use of intensive community services
(2) are dually diagnosed with mental illness and substance abuse,
(3) have a history of interactions with the criminal justice system, including arrests for vagrancy and other misdemeanors, or
(4) are currently homeless.

Children with serious emotional disturbance who:

(1) are at risk of out-of-home placement,
(2) are dually diagnosed with serious emotional disturbance and substance abuse, or
(3) as a result of their disorder are at high risk for the following significant adverse outcomes: attempted suicide, parental relinquishment of custody, a brush with the law, behavior dangerous to self or others, running away or being homeless.

By way of *Set-Aside Funds* the MHBG also supports national data collection and technical assistance activities on mental health issues of local and national importance. A mandatory 5 percent set-aside is used to support technical assistance, data collection and evaluation to the States and in recent years, standards development for performance-based managed care has been a top priority. The set-aside funding is used to established a partnership between CMHS and the States to help:

- **$** improve effectiveness and cost efficiency of mental health services delivery;
- **$** evaluate the quality and efficiency of State and local service programs;
- **$** respond to changes in the financing and delivery of mental health services; and
- **$** increase involvement of consumers and family members in all aspects of services.

Technical Assistance: The Center provides on-site technical assistance to States and regions on all issues of importance to mental health planning, service delivery, and evaluation. CMHS supports special mental health-related projects and events, including regional and national conferences; offers State mental health authorities, consumers, families, and State planning councils the resources of a comprehensive library of resource materials; communicates electronically with the mental health community through the World Wide Web and a forum on the National Mental Health Knowledge Exchange Network; maintains a database of expert consultants; and publishes a quarterly newsletter. CMHS also supports technical assistance and analysis focusing on special populations or service issues. Recent activities include analysis and technical assistance related to the elderly population, development of cultural competence standards for managed care systems, and development of training protocols for behavioral health professionals working in primary care settings.

Technical assistance can come in the form of a publication, national meeting etc. For example, on September 15, 1998, CMHS and CSAT released the results of a major study of national expenditures for mental health, alcohol, and other drug abuse treatment. This study, which is the first major update of spending estimates since those published by Rice et al. in 1990, is the result of a collaboration between the managed care offices in the two centers. Estimates are presented by payer and type of provider for 1996, and trends since 1986 are identified. In addition, the study provides estimates that allow direct comparison with those published by HCFA for all health care.

A key finding from the study indicated that of the total $79.3 billion spent nationally on treatment of mental health and abuse of alcohol and other drugs, $66.7 billion was for treatment of mental illness. Other key findings from the study were published in the September/October, 1998 issue of Health Affairs. The full report, National Expenditures for Mental Health, Alcohol and Other Drug Abuse Treatment, 1996, is available from the CMHS Knowledge Exchange Network. Unlike previous studies, CMHS and CSAT intend to update these estimates annually, to ensure that information on national spending for MH/SA services is kept current.

Data Collection/Essential National Benchmark Information: The National Reporting Program collects essential information on the organization, financing, and operation of mental health organizations, general hospital psychiatric services, and managed behavioral healthcare organizations. Such information covers both public and private systems of care. To examine changes in the types of persons served, surveys of consumer characteristics and service use are conducted periodically. Special projects have been undertaken to examine the availability and use of mental health services in all types of criminal justice settings, and in consumer-operated self-help programs. Numerous requests are received by this program for benchmark statistical information. A biennial publication, Mental Health, United States, is prepared to examine key policy issues in the field and to provide a compilation of statistical information.

Data Collection/Information Infrastructure: To respond to the needs for improved quality tools, the Mental Health Statistics Improvement Program is currently engaged in several initiatives. These include a project to define a new, consensually based information system for mental health that incorporates population data as well as services, outcome, and performance indicator information. A second project tests the feasibility of a Consumer-Oriented Report Card for behavioral healthcare plans. A third project pilots a set of performance indicators for the State mental health agencies as described immediately below.

Data Collection/Partnership for Planning and Performance: Over time, an increasing awareness has developed regarding the critical importance of accountability. To successfully meet the needs of persons with mental illness, States and others must be able to document that funds have been expended carefully and that desired effects have been achieved. The Partnership for Planning and Performance project will enhance the management and reporting capacity of States and will serve as a starting point for comparability of performance indicators among State mental health systems. The project will provide necessary lessons for CMHS to use in considering accountability for State systems in the future. The project has three phases: feasibility assessment, pilot testing, and implementation. Phase one of this project, feasibility assessment, is completed and awards to 16 States for the phase two pilot of performance indicators were made in FY 1998.

Funding levels for the past five fiscal years were as follows:

	Funding	FTE	
1995	$277,919,000	11	1996
275,420,000	11		
1997	275,420,000	11	
1998	275,420,000	11	
1999	288,816,000	11	

Data Elements Used to Calculate State Allotments

FY 1999: The 1999 State allotments under the Block Grant were determined after implementing the minimum allotment provisions of the Appropriation Act for fiscal year 1999. Section 218 of Public Law 105-277 permitted the Secretary to implement current law including the change to the use of non-manufacturing wages, but established minimum allotments. The general principle of the minimum allotments was that no State would be allotted less than the amount they received in fiscal year 1998.

The 1999 State allotments were generated using the following factors:

- Total Personal Income (TPI) - Bureau of Economic Analysis, Department of Commerce, downloaded from BEA website, Personal Income by State and Region, for years 1994-1996.

- Resident Population - Bureau of the Census, Department of Commerce, downloaded from Census website, Annual Time Series of Population Estimates by Age and Sex, By Single Year of Age and Sex, data as of 7/1/1996.

- Total Taxable Resources (TTR) for years 1994-1996 - Office of Economic Policy, Department of the Treasury, provided directly to OAS.

- Population data for the territories based on 1990 Census Data except Micronesia and the Marshall Islands. Population data for Micronesia and the Marshall Islands are based on 1980 census data and the average rate of population change from the 1980 to the 1990 census. Because Micronesia and the Marshall Islands had entered into a Compact of Free Association with the United States, they were no longer considered territories in 1990 and therefore were included in the 1990 census.

- A Cost of Services Factor which includes the following: Fair Market Rents for the Section 8 Housing Assistance Payments Program **C** Fiscal year 1997, from the U.S. Department of Housing and Urban Development, *Federal Register*, September 20, 1996, Vol. 61, No. 184, pages 49576-49635, from website *http://www.hud.gov* and then *ftp@ftp.aspemsys.com*. 1990 Census mean hourly wages for selected industries and occupations (special data file prepared by the Bureau of the Census) updated using the percent change for HCFA mean hourly hospital wages (unadjusted) for FY 1990 (from a special data file prepared by the Health Care Financing Administration) and FY 1993 hourly hospital wages developed from the FY 1997 HCFA Hospital Inpatient Prospective Payment System Wage Rates [published in the *Federal Register*, August 30, 1996, Vol. 61, Number 170, pages 46165-46215 with corrected data published in the *Federal Register* December 19, 1996, Vol. 61, Number 245, pages 66919-66923] in the HCFA public use file AHCFA Hospital Wage Index Survey File@ of Hospital Inpatient Prospective Payment System FY 1997 Rates downloaded from website *http://www.hcfa.gov/stats/pufiles.htm* and corrected per the December 1996 revisions.

FY 2000: Since the minimum allotment provisions of P.L. 105-277 applied only to fiscal year 1999 funds, State allotments for FY 2000 will be determined using current law including the use of non-manufacturing wage data in calculating the cost of service factor. The factors that were used in producing the FY 2000 table are:

- Total Personal Income (TPI) - Bureau of Economic Analysis, Department of Commerce, downloaded from BEA website *http://www.bea.doc.gov/bea/dr/spitbl-d.htm#table2* - Table 2, Personal Income by State and Region, 1993-1997, release date 9/14/98, also available from *http://www.bea.doc.gov/bea/ar1098rem/table1.htm.*

- Resident Population - Bureau of the Census, Department of Commerce, downloaded from Census website, text file AG9797.txt, 1990-to-1997 Annual Time Series of Population Estimates by Age and Sex, By Single Year of Age and Sex, public release date 7/21/98. Census website is *http://www.census.gov/population/estimates/state/stats/ag9797.txt*. (data as of 7/1/97).

- Total Taxable Resources (TTR) - Office of Economic Policy, Department of the Treasury, provided directly to OAS via e-mail, filename NM98EST.wk4, release date 9/30/98, Total Taxable Resources, 1994-1996.

- Population data for the territories based on 1990 Census Data except Micronesia and the Marshall Islands. Population data for Micronesia and the Marshall Islands are based on 1980 census data and the average rate of population change from the 1980 to the 1990 census. Because Micronesia and the Marshall Islands had entered into a Compact of Free Association with the United States, they were no longer considered territories in 1990 and therefore were included in the 1990 census.

- A Cost of Services Factor which includes the following: Fair Market Rents for the Section 8 Housing Assistance Payments Program **C** Fiscal year 1997, from the U.S. Department of Housing and Urban Development, *Federal Register*, September 20, 1996, Vol. 61, No. 184, pages 49576-49635, from website *http://www.hud.gov* and then *ftp@ftp.aspemsys.com*. 1990 Census mean hourly wages for selected industries and occupations (special data file prepared by the Bureau of the Census) updated using the percent change for HCFA mean hourly hospital wages (unadjusted) for FY 1990 (from a special data file prepared by the Health Care Financing Administration) and FY 1993 hourly hospital wages developed from the FY 1997 HCFA Hospital Inpatient Prospective Payment System Wage Rates [published in the *Federal Register*, August 30, 1996, Vol. 61, Number 170, pages 46165-46215 with corrected data published in the *Federal Register* December 19, 1996, Vol. 61, Number 245, pages 66919-66923] in the HCFA public use file AHCFA Hospital Wage Index Survey File@ of Hospital Inpatient Prospective Payment System FY 1997 Rates downloaded from website *http://www.hcfa.gov/stats/pufiles.htm* and corrected per the December 1996 revisions.

The Mental Health Block Grant contributes to the achievement of Goal 3--Assure Services Availability/Meet Targeted Needs. See GPRA plan for standard measures and program specific measures. Baseline and update data are not yet available, but outcome data will be collected on a voluntary basis in the FY 1999 Block Grant application.

Rationale for the Budget

The FY 2000 President=s budget proposes that the Mental Health Block Grant be funded at $358,816,000, an increase of $70,000,000 over the FY 1999 enacted level. This level of funding will assure that each State will receive an increase over their FY 1999 allotment. This increase will reinvigorate the State systems of community based care and help States expand services to respond to the continuing unmet need of adults with serious mental illness and children with serious emotional disturbances. Every night, about 200,000 people with major mental illness are homeless; and each year, more than 1 million youth come in contact with the juvenile justice system. Reports indicate that these unmet mental health needs result in costs to the nation that are equal to costs for cancer or heart disease.

The infusion of these additional funds will be critical in enabling State mental health authorities to significantly influence efforts to reorganize health care delivery systems to ensure sufficient access to quality mental health

care for underserved populations. The increase will help States with the cost of new medications and treatment modalities, school violence abatement programs, jail diversion programs for youths, post incarceration and post hospitalization community service programs, and community-based suicide prevention programs for youths and the elderly. This increase will allow States and communities to focus on gaps between needs and services, such as case management or school based services for persons who do not meet criteria for other funding streams, yet for whom services would prevent suffering and increased expenditures at later points of entry for care. States will be better equipped to respond to mental health needs of persons moving from welfare-to-work as a result of welfare reform legislation and to co-occurring disorders among individuals with mental heath and substance abuse problems.

Service Expansion

There are numerous communities within the States and Territories that will be able to begin to address their needs by expanding their comprehensive community based services to adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED). States will be able to expand the access and availability of rehabilitation, employment, housing, educational, medical, health, mental health, and other support services. Outreach and services to homeless individuals with SMI and persons residing in rural areas will also be expanded with additional funds. The expansion of the comprehensive community-based mental health service system will allow for further reduction in the numbers of individuals residing in inpatient or residential institutions and allow them to function in the community to the maximum extent of their capabilities.

Additionally, this increased funding will provide essential mental health services for adults and children. Research has indicated that provisions of basic services such as physician and medication, alone, generally are not effective. The services listed below are among those which have demonstrated success with our Nation=s children and adults living with a serious mental disorder. Knowledge being gained from the KDA programs is finding a natural home in the Mental Health Block Grant Program being implemented in States across the Nation.

For Adults:

- assertive community treatment, including the Program of Assertive Community Treatment (PACT)
- hospital discharge planning, beginning the day of admission and including the involvement of the individual=s community case manager,
-- psychiatric rehabilitation,
-- integrated mental health and substance abuse treatment for those with dual diagnosis,
-- case management, including assistance obtaining affordable and appropriate housing in community settings, income support and other benefits,
-- consumer peer support programs,
-- consumer-run drop-in and other community programs,
-- family education and training on management of mental illness and on available services,
-- medication education and management,
-- in collaboration with criminal justice agencies, programs to identify and refer persons with serious mental disorders to appropriate community-based service providers following contact with the law,

-- mental health treatment for welfare recipients making the transition from welfare to work as a result of welfare reform legislation, and
-- other evidenced-based service interventions or innovative services.

For Children:
-- day treatment programs (school-based and free-standing),
-- school-based mental health services, including crisis services, mental health consultation for teachers and administrators, behavioral aides and other services, except that such funds shall not be used for services covered under a child=s Individualized Education Program through the Individuals with Disabilities Education Act,
-- intensive in-home services,
-- behavioral aides and community mentors,
-- family education and training on management of serious emotional disturbance and on available services,
-- crisis mental health services,
-- family support services,
-- family respite care services,
-- case management, and
-- other wraparound services designed to keep the child safely in the home or, if appropriate, other community setting, e.g., transportation, housing, child care.

Criminal Justice Issues and Mental Health

The sheer magnitude of people with serious psychiatric disorders entering jails is staggering. On an average day, between 9% of men and 18.5% of women entering local jails have a history of serious mental illness, a rate higher than that of the general population and of the general prison population.[2] Because of the rapid turnover in the jail population, this translates into nearly 700,000 admissions to jails annually constituting people with serious mental disorders. Fewer than one-half (48%) of jails work with community mental health centers in providing mental health services. States need additional Block Grant funding for discharge planning and to ensure post incarceration, community-based services to individuals exiting local jails and prison systems.

Welfare Reform

Welfare reforms for some people are resulting in increasing poverty and family stress without supporting and strengthening a family=s psychological resources. Such reforms too often have negative consequences on family members, especially children. An increase in the Mental Health Block Grant can help provide basic psychological support services to independent adults and families, through collaboration with public welfare systems and other human services, to thwart the intensification of stressors associated with the

[2] Teplin, LA; Abram, K.M.; and mcCelland, G.M. (1996) Prevalence of psychiatric disorders among incarcerated women. Archives of General psychiatry. 53:505-11.

transition to living without public welfare benefits.

Co-Occurring Disorders

Additional Block Grant funding will be of particular help to States as they try to respond to the growing problem of persons with both mental health and substance abuse disorders. A national survey has found that 8 to 11 million people have both a mental health and substance related problem. Alcohol-use disorders and/or drug abuse conditions commonly occur in people with other severe mental illnesses, such as schizophrenia or bipolar disorder; and can exacerbate their psychiatric, medical and family problems. Block Grant funds will be used by States to more effectively improve detection of alcohol-related and drug abuse problems, establish diagnoses, and develop appropriate treatment plans for persons with severe mental illness.

Set-Aside Funds for Technical Assistance and Data Collection

Additional block grant funds will provide funds for continuing and new technical assistance activities and data collection. For example, studies and policy analyses both point to a precipitous decline in the availability of financial resources for mental health services. This decline, in part, may be attributed to the greater accountability now required by payers for the resources they expend. Since the mental health field does not have consensually agreed upon quality tools -- practice guidelines, outcome measures , report cards, and performance indicators -- those negotiating managed care contracts cannot document quality and outcome of care for payers. As a result, payers have reduced their behavioral healthcare benefit costs 54 percent between 1988 and 1997 -- a cut of 670 percent more than cuts taken by general healthcare benefit costs. To address this, additional set-aside funds will continue to support and expand the collection of essential national benchmark information, the development of information infrastructure, and partnership for planning and performance activities.

Substance Abuse and Mental Health Services Administration

Community Mental Health Services Block Grant, FY 1998-2000

State / Territory	FY 1998 Actual	FY 1999 Appropriation	FY 2000 Estimate	Difference +/- 2000 vs 1999
Alabama	$3,875,371	$3,971,612	$5,289,314	$1,317,702
Alaska	429,159	588,437	721,492	133,055
Arizona	3,870,297	4,579,039	5,779,821	1,200,782
Arkansas	2,232,840	2,316,177	3,008,799	692,622
California	34,513,517	35,155,183	46,535,232	11,380,049
Colorado	3,750,325	3,750,325	4,347,331	597,006
Connecticut	3,241,039	3,241,039	4,025,643	784,604
Delaware	730,894	730,894	808,105	77,211
District Of Columbia	596,523	596,523	726,105	129,582
Florida	12,239,345	15,386,850	20,162,974	4,776,124
Georgia	6,194,485	7,389,430	9,741,379	2,351,949
Hawaii	1,243,596	1,243,596	1,506,808	263,212
Idaho	1,070,863	1,070,863	1,389,768	318,905
Illinois	11,194,433	11,194,433	13,557,580	2,363,147
Indiana	6,332,808	6,332,808	7,074,787	741,979
Iowa	2,740,750	2,740,750	3,095,824	355,074
Kansas	2,374,949	2,374,949	2,789,115	414,166
Kentucky	3,670,758	3,733,632	4,874,405	1,140,773
Louisiana	4,376,363	4,376,363	5,331,372	955,009
Maine	1,265,584	1,265,584	1,511,891	246,307
Maryland	5,707,845	5,707,845	7,006,130	1,298,285
Massachusetts	6,360,517	6,360,517	7,548,019	1,187,502
Michigan	10,771,969	10,771,969	11,725,962	953,993
Minnesota	4,438,360	4,438,360	4,934,026	495,666
Mississippi	2,456,254	2,531,443	3,302,968	771,525
Missouri	4,797,839	4,797,839	5,910,467	1,112,628
Montana	873,926	873,926	1,036,533	162,607
Nebraska	1,300,783	1,367,377	1,740,914	373,537
Nevada	1,450,044	1,689,409	2,202,414	513,005
New Hampshire	1,154,144	1,154,144	1,290,056	135,912
New Jersey	8,090,233	8,107,027	10,383,870	2,276,843
New Mexico	1,426,307	1,490,170	1,887,309	397,139
New York	17,669,287	18,640,661	23,953,168	5,312,507
North Carolina	6,238,341	6,498,831	8,550,899	2,052,068
North Dakota	548,729	579,458	740,843	161,385
Ohio	12,772,348	12,772,348	12,946,890	174,542
Oklahoma	3,049,628	3,049,628	3,927,023	877,395
Oregon	3,228,481	3,228,481	3,770,612	542,131
Pennsylvania	12,024,336	12,024,336	14,525,618	2,501,282
Rhode Island	895,462	1,013,252	1,294,391	281,139

Substance Abuse and Mental Health Services Administration

Community Mental Health Services Block Grant, FY 1998-2000

State / Territory	FY 1998 Actual	FY 1999 Appropriation	FY 2000 Estimate	Difference +/- 2000 vs 1999
South Carolina	3,386,545	3,451,050	4,529,118	1,078,068
South Dakota	579,888	611,875	785,512	173,637
Tennessee	4,613,933	4,896,610	6,454,889	1,558,279
Texas	16,264,840	19,588,185	25,520,651	5,932,466
Utah	1,579,290	1,654,986	2,222,499	567,513
Vermont	611,017	611,017	694,117	83,100
Virginia	6,162,479	6,982,802	8,988,622	2,005,820
Washington	6,001,118	6,001,118	7,196,398	1,195,280
West Virginia	1,941,957	1,941,957	2,264,098	322,141
Wisconsin	5,001,980	5,001,980	5,737,161	735,181
Wyoming	382,485	382,485	413,150	30,665
State Sub-total	**257,724,264**	**270,259,573**	**335,762,072**	**65,502,499**
American Samoa	50,000	50,000	59,238	9,238
Guam	128,389	134,969	168,636	33,667
Northern Marianas	50,000	50,000	54,896	4,896
Puerto Rico	3,396,063	3,570,111	4,460,636	890,524
Palau	50,000	50,000	50,000	0
Marshall Islands	50,000	50,000	56,657	6,657
Micronesia	102,115	107,349	134,125	26,777
Virgin Islands	98,168	103,199	128,940	25,742
Territory Sub-total	**3,924,735**	**4,115,628**	**5,113,128**	**997,500**
SAMHSA Set-Aside	**13,771,001**	**14,440,799**	**17,940,800**	**3,500,001**
GRAND TOTAL	**$275,420,000**	**$288,816,000**	**$358,816,000**	**$70,000,000**